Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Shore Surgicenter

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-13-2500-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient was developing Cellulitis around the skin around the K-wires. Per Dr. Polsen both wires needed to be removed due to increase of infection, preventing a risk for another surgery."

Amount in Dispute: $13,090.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Absent preauthorization, medical emergency is required for the procedure to warrant reimbursement. The rational for the surgery does not meet the definition of medical emergency at Rule 133.2. "

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2012	20680, 76000, 64450	$13,090.06	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
3. 28 Texas Administrative Code §133.2 defines emergency.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent
   - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor support that condition required immediate surgery?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600(p)(2) states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services. Review of the submitted documentation finds:
    a. Operative Report – Indications, "At this point in time there appears to be no evidence of infection, though he has had a tendency to get some cellulitis around the skin around the wires.

    The submitted documentation does not support the definition of emergency as defined by 28 Texas Administrative Code §133.2(5)(A)(B) or "Emergency - Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part;…" Therefore prior authorization was required but not approved at the time of the disputed service.
2. Requirements of division Rule134.600 not met, no payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.